No. 00-1471

Supreme Court, U.S.
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In The

# Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., et al.,

*Petitioners,*

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,

*Respondent.*

**On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit**

## BRIEF FOR RESPONDENTS

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## QUESTION PRESENTED

The question presented is whether Ky. Rev. Stat. §304.17A-270, Kentucky's Any Willing Provider ("AWP") statute and Ky. Rev. Stat. §304.17A-171(2), the chiropractic AWP statute (referred to collectively as "Kentucky's AWP statutes"), are preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq., or are they saved from preemption because they are state statutes that "regulate the business of insurance?"

## PARTIES

Petitioner, Kentucky Association of Health Plans ("KAHP"), includes six insurers holding certificates of authority issued by the Kentucky Department of Insurance, pursuant to Ky. Rev. Stat. § 304.3-160, to transact the business of insurance as health maintenance organizations ("HMO") in the Commonwealth of Kentucky.[1] Other petitioners are Humana Health Plan of Ohio, Inc. ("Humana of Ohio"), which succeeded plaintiff-appellant Choicecare Health Plans, Inc. and Aetna Health Inc. (OH) ("Aetna of Ohio") which succeeded plaintiff-appellant Aetna Health Plans of Ohio, Inc. Humana of Ohio, is an insurer, which holds a certificate of authority issued by the Kentucky Department of Insurance to operate as an HMO, as is Aetna of Ohio.

HMPK, Inc. and HPLAN, Inc., also plaintiffs-appellants below, have been succeeded by petitioner Humana Health Plan, Inc. As stated above, Humana Health Plan, Inc. is a member of the KAHP. Advantage Care, Inc. and FHP of Ohio, Inc., also plaintiffs-appellants below, are no longer parties to this action and are not petitioners in this Court.

[1] The members include Anthem Health Plans of Kentucky, Inc. d/b/a Anthem Blue Cross and Blue Shield of Kentucky, Inc., Aetna Health Inc., Bluegrass Family Health, Inc., CHA HMO, Inc. d/b/a CHA Health, Humana Health Plans, Inc. and United HealthCare of Kentucky, Ltd.



## PARTIES – Continued

Respondent, Janie A. Miller, succeeded to the position of Commissioner of Insurance for the Kentucky Department of Insurance (sometimes referred to as "The Department") after the Sixth Circuit Court of Appeals entered judgment in this case, and is accordingly substituted as respondent pursuant to S. Ct. R. 35.3.

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## STATEMENT OF THE CASE

### I. RELATIONSHIP OF THE PARTIES

Each Petitioner holds a certificate of authority issued by the Kentucky Department and, therefore, each Petitioner must comply with all applicable insurance statutes in Ky. Rev. Stat. Chapter 304 ("the insurance code") in order to keep its certificate of authority in good standing.[2] Each Petitioner is issued a certificate of authority that allows it to transact the business of insurance as an HMO.[3] As insurers, petitioners offer different types of health benefit plans including HMO plans, Preferred Provider Organization ("PPO") plans, and Point of Service ("POS") plans. PPO and POS health benefit plans offer both in-network and out-of-network benefits. Additionally, Anthem Blue Cross and Blue Shield offers a traditional fee-for-service plan. Because these plans are considered "health benefit plans" for the purposes of subtitle 17A of the insurance code, they must meet all the requirements of subtitle 17A.

Among her other duties and responsibilities required by statute, Commissioner Janie A. Miller is required to "inquire into violations of [the insurance code and] . . .

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[2] The commissioner may revoke or suspend an insurer's certificate of authority for willfully violating or willfully failing to comply with any provision of the insurance code. See Ky. Rev. Stat. § 304.3-200.

[3] In *Rush Prudential*, the Court recognized that HMOs "are almost universally regulated as insurers under state law." *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151, 2163 (2002). In Kentucky, petitioners are regulated as insurers.

enforce the provisions of [the insurance code] with impartiality and [to] execute the duties imposed upon [her] by [the insurance code]." Ky. Rev. Stat. § 304.2-100(2).

## II. STATUTORY SCHEME

Like many state legislatures, the Kentucky General Assembly has struggled with the often-competing interests between healthcare insurers (cost-containment, managing care) and insureds (access to affordable but quality care). In 1994, the Kentucky General Assembly passed sweeping healthcare reform, which greatly affected the insurance code, particularly by the creation of subtitle 17A of Ky. Rev. Stat. Chapter 304.[4] Subtitle 17A governs all insurers doing business in the Commonwealth and issuing health benefit plans. "Insurer" is defined in Ky. Rev. Stat. 304.17A-005(23). "Health benefit plan" is defined in Ky. Rev. Stat. 304.17A-005(18). The 1994 health care reform was a culmination of two years of study and testimony conducted by the Kentucky General Assembly on the problems in the Kentucky health care system. The General Assembly enacted health care reform to respond to the following problems: (a) lack of insurance and inadequate access to health care; (b) financial barriers to access; (c) insurance marketplace practices; (d) administrative costs in private insurance policies; (e) market fragmentation and purchaser confusion; and (f) poor allocation of health care providers in the state. See *A Citizen's Handbook, Kentucky's Health Care Reform, A Profile of HB 250:*

[4] House Bill ("HB") 250, An Act relating to health care reform.



*Provisions, Time Line, Q & A*; Legislative Research Commission; Frankfort, Kentucky, May 1994.

The AWP provision was an integral part of the statutory scheme associated with Kentucky's 1994 healthcare reform. Kentucky's AWP provision is now codified in Ky. Rev. Stat. § 304.17A-270.[5] (Pet. App. 89a) In 1996, the Kentucky General Assembly enacted an additional AWP provision that required all insurers issuing health benefit plans that included chiropractic benefits to allow any chiropractor, who was willing to agree to the terms and conditions set by the insurer, to participate in the health benefit plan. (Pet. App. 89a-91a). Kentucky's chiropractic AWP is codified in Ky. Rev. Stat. § 304.17A-171(2). Since 1994, the Kentucky General Assembly has continued to struggle with the competing interests of insurers and insureds, resulting in some of the HB 250 patient protections being repealed. However, Kentucky's AWP statutes remain in force.[6]

The General Assembly passed Kentucky's AWP statutes as an integral and necessary part of health care reform. As with most added, and sometimes mandated, consumer benefits to insurance policies, Kentucky's AWP statutes may increase the cost on insurers as Petitioners

[5] Kentucky's AWP was originally codified in Ky. Rev. Stat. § 304.17A-110(3) but was later recodified in Ky. Rev. Stat. § 304.17A-270, changing the phrase "health care benefit plans" to "health insurer."

[6] In 2000, the Kentucky General Assembly passed HB 757, another patient protection bill. That bill amended Ky. Rev. Stat. § 304.17A-505 requiring insurers offering managed care plans to disclose to their insureds, upon enrollment and upon request, that the insurer will take any willing provider. This law has not been challenged.

maintain. (Pet. Br. 5, fn. 4). However, the Kentucky General Assembly decided, rightly or wrongly, that the need for and benefits of an AWP law for insureds outweighed the possibility of increased costs for insurers.[1]

## III. PROCEEDINGS BELOW

Petitioners continue to maintain that Kentucky's AWP statutes are preempted by ERISA as they "relate to" and have a "connection with" employee welfare benefit plans and are not "saved" from preemption as they do not regulate the business of insurance.

The Sixth Circuit Court of Appeals agreed with Petitioners that Kentucky's AWP statutes are "related to" and have a "connection with" employee welfare benefit plans; however, a majority of the Court concluded that these statutes were saved from preemption because they

[1] The issue of whether AWP laws increase costs and by how much is open to debate. See James W. Childs, Jr., *You May Be Willing, But Are you Able?: A Critical Analysis of "Any Willing Provider" Legislation*, 27 Crumb. L. Rev. 199, 212 (1996-1997) ("[T]here is some evidence that health care costs have not risen in those states which have enacted AWP legislation.") However, the issue of cost is irrelevant to the discussion of whether the law in question is a law that regulates insurance. Mandated benefits, and other consumer protections, increase cost. See The Factors Fueling Rising Healthcare Cost, prepared by PriceWaterhouseCoopers for American Association of Health Plans, April 2002, *available at* www.aahp.org/Internallinks/PWCFinal Report.pdf. However, mandated benefit laws are laws that regulate the business of insurance. *Metropolitan Life v. Massachusetts*, 471 U.S. 724 (1985). The Sixth Circuit agreed the cost is not relevant to the discussion – "the decision of the Kentucky legislature to enact AWP laws is one left to the wisdom of that deliberative body, and the possible economic ramifications of its AWP laws should not concern this court." Pet. App. 34a, fn. 18.



"regulate insurance." Pet. App. 7a-19a; *id.* at 38a. Concluding as such, the Sixth Circuit affirmed the decision of the United States District Court for the Eastern District of Kentucky.

Relying on the "common-sense" test as set forth in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 740 (1985) and *UNUM Life Insurance of America v. Ward*, 526 U.S. 358, 367 (1999), the Sixth Circuit concluded that Kentucky's AWP statutes are saved from preemption because they are statutes that "meet[] the common sense test in that [they] clearly [do] regulate insurance." *Id.* at 20a-30a. The Sixth Circuit also found that Kentucky's AWP statutes are saved from preemption because they meet the "three factors employed to determine whether the regulation fits within the 'business of insurance' as that phrase is used in the McCarran-Ferguson Act." *Id.* at 20a, citing, *UNUM*, 526 U.S. at 367-68.

Even though the Sixth Circuit found that Kentucky's AWP statutes meet the three McCarran-Ferguson factors, it noted that this Court, in *UNUM*, established that the three McCarran-Ferguson factors "are not required to be satisfied before a state law can be found to be a law regulating insurance." *Id.* at 38a. Instead, the three McCarran-Ferguson factors are "checking points" or "guideposts" for the courts. *Id.* The fact that a state law does not have to meet all three McCarran-Ferguson factors to survive preemption was reiterated last term in *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151 (2002) (finding that Illinois' external review law meets two of the three McCarran-Ferguson factors and is a law that

regulates the business of insurance and, therefore, is saved from preemption).

## SUMMARY OF THE ARGUMENT

I. Petitioners are insurers holding certificates of authority issued by the Kentucky Department of Insurance. Therefore, Petitioners must comply with the state regulatory requirements of Kentucky's AWP statutes. Petitioners must comply with Kentucky's AWP statutes regardless of whether they issue a health benefit plan in the individual, association, or fully insured large or small group market. Kentucky's AWP statutes provide the benefit of an open panel for all individuals covered under a Kentucky health benefit plan. Because Kentucky's AWP statutes confer a benefit on employees covered under a fully insured employee benefit plan, these statutes have a "connection with" fully insured employee benefit plans.

II. Kentucky's AWP statutes are laws that "regulate insurance" within the meaning of ERISA's saving clause. Kentucky's AWP statutes meet the two-prong test used by courts to determine whether a law "regulates insurance" within the meaning of the saving clause.

As a matter of common sense, both of these statutes regulate insurance because they are specifically directed at the insurance industry and they regulate insurance practices within that industry. In addition, both of these statutes meet all three McCarran-Ferguson factors, confirming that they are laws that "regulate insurance" as a matter of common sense. Kentucky's AWP statutes operate to spread risk by providing a greater benefit to Kentucky insureds similar to the mandated mental health benefit in *Metropolitan Life*. These laws also mandate a



contract term between the insurer and the insured and are an integral part of the insurer/insured relationship similar to the external review law in *Rush Prudential*. Finally, Kentucky's AWP laws are requirements imposed only on Kentucky insurers, issuing health benefit plans, and, therefore, are laws that are limited to the insurance industry.

III. Kentucky's AWP statutes are a state regulatory scheme to benefit insureds and, therefore, are distinguishable from the private pharmacy agreements that were the subject of an antitrust action in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). The insurer, in *Royal Drug*, attempted to enter into pharmacy agreements as a business decision to lower its costs. Kentucky's AWP statutes function in a completely different manner than the private pharmacy agreements in *Royal Drug*. These statutes regulate the insurance practice of arbitrarily limiting provider panels. These statutes also confer a benefit on Kentucky insureds by providing greater access to health care. Therefore, Kentucky's AWP statutes regulate the business of insurance.

## ARGUMENT

### I. KENTUCKY'S AWP STATUTES PROVIDE THE BENEFIT OF GREATER ACCESS TO CARE FOR INDIVIDUALS COVERED UNDER HEALTH BENEFIT PLANS ISSUED BY KENTUCKY INSURERS REGARDLESS OF WHETHER THE POLICY IS ISSUED TO AN INDIVIDUAL, ASSOCIATION, OR FULLY INSURED EMPLOYER GROUP

Any ERISA preemption analysis must first start with whether the state law at issue "relates to" employee

benefit plans. Under Section 514(a) of ERISA, 29 U.S.C. § 1144(a), the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." To determine whether a state law "relates to" an employee benefit plan "yield[s] a two-part inquiry: A law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) 'if it [1] has connection with or [2] reference to such a plan.'" *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997) (citation and internal quotation marks omitted).

Next, an ERISA preemption analysis requires a determination as to what is the "plan." "Rules governing collection of premiums, definition of benefits, submission of claims, and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan." *Pegram v. Herdrich*, 530 U.S. 211, 223 (2000), citing *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 977 (C.A.5 1991). An "agreement between an HMO and an employer who pays premiums may . . . provide elements of a plan by setting out rules under which beneficiaries will be entitled to care." *Pegram*, *supra* at 223. When an employer decides to purchase insurance rather than self-insure, an insurer's provider directory, and certificate of coverage, issued to plan beneficiaries, provide elements of the employee benefit plan. The certificate of coverage and provider directory inform the plan participant and beneficiary how they access providers and which providers they may access.[8]

[8] Upon enrollment, the certificate of coverage in Joint Appendix C (pages 21a-106a) is given to a plan participant along with a provider directory as required by Ky. Rev. Stat. § 304.17A-590 and Ky. Rev. Stat.
(Continued on following page)



### A. Kentucky's AWP statutes relate to ERISA plans to the extent that they mandate a benefit structure for fully insured ERISA plans.

The Department acknowledges that Petitioners, because they are companies licensed to transact the business of insurance in the Commonwealth, can and do issue health benefit plans to employer groups. (See Joint Appendix 21a-106a). Because Kentucky's AWP statutes "mandate[] employee benefit structures" for insured employee benefit plans by requiring open networks rather than closed, they have a "connection with" ERISA plans. Cf. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995) (holding that a New York statute requiring hospitals to collect a surcharge from patients who are covered under ERISA plans not "related to" employee benefit plans). Kentucky's AWP statutes bear "indirectly but substantially on all insured benefit plans," *Metropolitan Life*, 471 U.S. at 739, by requiring employers that choose not to self-insure to purchase a health benefit plan that provides greater access to health care providers for plan participants and beneficiaries. An individual covered under a self-insured plan would only have access to a limited panel of providers dictated solely by the employer plan.

§ 304.17A-510. The certificate includes definitions of terms used in the certificate. Non-participating hospital, non-participating physician, and non-participating provider are defined on page 28a. Participating hospital, participating physician, and participating provider are defined on page 29a. On page 61a, the certificate provides information to the plan participant and beneficiary regarding the difference in cost (risk sharing) if they receive services rendered by non-participating physicians rather than a participating physician.

Insurance regulation, by its very nature, places requirements on insurers and the plans they offer. These state regulatory requirements, like Kentucky's AWP statutes, do not disappear even when an insurer offers policies to employers and covers employees in insured employee benefit plans. However, this does not change the fact that Kentucky's AWP statutes, or other insurance statutes, are laws that regulate the business of insurance and are, therefore, saved from ERISA preemption under 29 U.S.C. § 1144(b)(2)(A).[9]

### B. Kentucky's AWP statutes are insurance laws that are directed toward insurers issuing health benefit plans in the Kentucky insurance market.

It is important to note what Kentucky's AWP statutes do not do. They do not single out ERISA plans for differing treatment. Cf. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (Georgia antigarnishment statute singled out ERISA plans for protective treatment and, therefore, was preempted). Kentucky's AWP statutes are not dependent on ERISA plans for its operations. Cf. *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992) (state law that required employers who provide health insurance for their employees to provide equivalent health insurance coverage for

[9] The nature of state insurance regulation, along with ERISA's preemption language and saving clause, demonstrates how ERISA's language "seems simultaneously to preempt everything and hardly anything" at the same time. *Rush Prudential*, 122 S.Ct. 2151, 2159 (2002).



injured employees eligible for worker's compensation was premised on the existence of ERISA plans). Petitioners are required to provide the benefit of open panels, as required by Kentucky's AWP statutes, when issuing any health benefit plan regardless of whether the health benefit plan is issued in the individual, association or group market.

Furthermore, Kentucky insurance statutes do not "deem" employee benefit plans to be insurance companies or insurers for the purposes of regulating them as such in violation of Section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), which prevents states from regulating self-insured plans under the guise of regulating insurance. See *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). Instead, Ky. Rev. Stat. § 304.17A-005(23) acknowledges the "deemer clause" and adheres to the requirements of that clause by defining insurer as "any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement *not exempt from state regulation by ERISA*" (Pet. App. 89a, emphasis added). Simply put, the Kentucky Department of Insurance does not regulate self-insured ERISA plans as insurance companies.

Considering the recent decision in *Rush Prudential*, 122 S.Ct. 2151 (2002), the Kentucky Department of Insurance acknowledges that, to the extent that Kentucky's AWP statutes mandate a benefit structure for fully insured employer groups, they "relate[] to" ERISA plans.

## II. KENTUCKY'S AWP STATUTES REGULATE INSURANCE AND ARE SAVED FROM PREEMPTION

A state law is saved from preemption if it is a law that "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). In *UNUM*

*Life Ins. Co. of America v. Ward*, 526 U.S. 358 (1999), the Court reaffirmed the two-prong test used in *Metropolitan Life* to determine whether a state law "regulates insurance" within the meaning of the ERISA saving clause. First, a court determines whether the state law regulates insurance from a common-sense view of the matter. Second, a court considers the three factors employed to determine whether the state law is a law that regulates the "business of insurance" as that phrase is used in the McCarran-Ferguson Act, 15 U.S.C. § 1012(a). The three McCarran-Ferguson factors are as follows: (1) whether the practice transfers or spreads risk; (2) whether it is an integral part of the insurer-insured relationship; and (3) whether the practice is limited to entities within the insurance industry. *UNUM*, 526 U.S. at 367-68. "Because the [McCarran-Ferguson] factors are guideposts, a state law is not required to satisfy all three ... criteria to survive preemption." *Rush Prudential*, supra at 2163.

As the Sixth Circuit correctly concluded, as a matter of common sense, Kentucky's AWP statutes regulate insurance and meet the three McCarran-Ferguson factors.

### A. As a matter of common sense, Kentucky's AWP statutes regulate insurance.

#### 1. The decision in *Rush Prudential* confirms that Kentucky's AWP statutes are directed toward the insurance industry.

The Sixth Circuit's determination that Kentucky's AWP statutes regulate insurance "as a matter of common sense," Pet. App. 19a-30a, is in compliance with this Court's precedents, including the most recent decision in



*Rush Prudential*. In *Rush Prudential*, it was reiterated that when "deciding whether a law 'regulates insurance' under ERISA's saving clause, [the Court will] start with a 'common-sense view of the matter.'" *Rush Prudential*, 122 S.Ct. at 2159, quoting *Metropolitan Life v. Massachusetts*, 471 U.S. at 740. Under the common sense view, "a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987); see *Rush Prudential*, 122 S.Ct. at 2159. Like the Illinois external review law considered in *Rush Prudential*, Kentucky's AWP statutes are "'directed toward' the insurance industry, and [are] 'insurance regulation[s]' under a 'commonsense' view." *Rush Prudential*, supra at 2163.

Only an "insurer," as defined in Ky. Rev. Stat. § 304.17A-005(23), issuing a "health benefit plan," as defined in Ky. Rev. Stat. § 304.17A-005(18) is required to comply with Kentucky's AWP statutes.[10] The Kentucky Department of Insurance is charged with the responsibility of issuing certificates of authority to all risk-bearing entities conducting the business of insurance in the Commonwealth.[11] Ky. Rev. Stat. § 304.3-150 and

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[10] Besides Petitioners, the Department of Insurance also issues certificates of authority to Property and Casualty insurers with a health insurance line of authority and Life and Health insurers. Some of these insurers issue health benefit plans that are PPO products. When these insurers issue health benefit plans, regulated under Ky. Rev. Stat. Chapter 304, subtitle 17A, and enter into provider agreements, they must also comply with Kentucky's AWP statutes. Most, if not all, of these insurers offer health benefit plans exclusively in the individual market and not to employer groups.

[11] The Kentucky Department of Insurance does not issue certificates of authority to any employer who chooses to have a self-insured

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§ 304.3-160. The Kentucky Department of Insurance is charged with the duty of enforcing all applicable statutes in Ky. Rev. Stat. Chapter 304 against all insurers holding valid certificates of authority. Kentucky's AWP statutes are located in subtitle 17A of the insurance code and are directed solely at those regulated entities issuing health benefit plans, including Petitioners. For these reasons, the Sixth Circuit correctly determined that Kentucky's AWP statutes "are [ ] specifically directed toward 'insurers' and the insurance industry and are ones that from a 'common sense view' regulate insurance." Pet. App. 25a. In reviewing that determination, this Court does not "normally disturb an appeals court's judgment on an issue so heavily dependent on analysis of state law." *UNUM*, 526 U.S. at 368.

**2. Kentucky's AWP statutes regulate the insurance practices of Kentucky insurers by prohibiting them from arbitrarily limiting access to providers.**

Petitioners assertion that Kentucky's AWP statutes "regulate neither insurers exclusively, nor the insurance practice of insurers" is completely without merit. See Pet. Br. p. 27. If Petitioners believe, as they contend, that allowing an enrollee a larger panel of health care providers to choose from is not a benefit to the enrollee, the Department submits that Petitioners are completely disconnected from the individuals they insure. As an insurance practice, Petitioners want to limit their provider

employee benefit plan. Therefore, self-insured employer groups are not considered insurers in the Commonwealth of Kentucky.



networks for their benefit and to the detriment of their insureds. This insurance practice is similar to an insurer's decision to not offer a benefit, limit the coverage of a benefit, or deny coverage of a benefit based solely on an internal decision of medical necessity. When the need arises, it is up to the states to regulate these insurance practices through laws such as mandated benefit laws, external review laws, and AWP laws. These patient protection laws shift some of the risk from the insured onto the insurer by prohibiting the insurer from placing limitations on access to care.

Insureds obtain their benefits through the health insurance contract and the certificates of coverage issued pursuant to that contract. Insurers deliver provider directories simultaneously with the certificates of coverage. The Department contends that certificates of coverage and provider directories are so interrelated as to make them virtually indistinguishable. Contained within all certificates of coverage are "plan delivery rules." Within the limitations set forth by state regulation, the insurer sets the rules. Those rules inform the insured of the "how, when, where, and why" he or she may see a provider. Insurers contract with providers for the benefit of their insureds. The insurance code contains numerous statutes that require the Department to regulate the insurer-provider relationship.[12] The Department enforces these

[12] The Department of Insurance requires managed care plans to demonstrate that "[a] provider network [is] . . . available to all persons enrolled in the plan within thirty (30) miles or thirty (30) minutes of each person's place of residence, to the extent those services are available." Ky. Rev. Stat. § 304.17A-515(1)(e). Insurers are required to file sample provider agreements with the Department. Ky. Rev. Stat.

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statutes for the benefit of insureds. See *Department of Treasury v. Fabe*, 508 U.S. 491 (finding that an Ohio liquidation statute furthered the goal of protecting policyholders and was a law enacted to regulate the "business of insurance.") Common sense tells us that unless there is a

§ 304.17A-527 and 806 Ky. Admin. Regs. 17:300. "A contract between a managed care plan and a physician shall not require the mandatory use of a hospitalist." Ky. Rev. Stat. § 304.17A-532. Insurers issuing managed care plans are prohibited from entering into contracts with providers that contain language that limit the provider's disclosure of information to the enrollee regarding the enrollee's medical condition or treatment. Ky. Rev. Stat. § 304.17A-530. Provider agreements shall contain "hold harmless" clauses pursuant to Ky. Rev. Stat. § 304.17A-527(1)(a). Provider agreements shall contain a "continuity of care" clause. Ky. Rev. Stat. § 304.17A-527(1)(b). Managed care plans are required to notify an enrollee if his or her primary care provider has been terminated from the plan. Ky. Rev. Stat. § 304.17A-525(3). When deciding whether to issue a certificate of authority to an HMO, the Commissioner may consider an HMOs provider agreements by provider type. Ky. Rev. Stat. § 304.38-060(2)(d). The Department regulates an insurer's responsibility to promptly pay a clean claim to a provider. Ky. Rev. Stat. § 304.17A-700 et.seq. The Department regulates the type of claims forms that insurers can require providers to use. Ky. Rev. Stat. § 304.14-135. As part of an insurer's responsibility to disclose the terms and conditions of a health benefit plan, the insurer must have "[m]easures in place to ensure the confidentiality of the relationship between an enrollee and a health care provider." Ky. Rev. Stat. § 304.17A-505(1)(h). Additionally, an insurer must inform an insured or an enrollee "that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer." Ky. Rev. Stat. § 304.17A-505(1)(k). A managed care plan is required to ensure that an enrollee has an adequate choice of participating primary care providers. Ky. Rev. Stat. § 304.17A-520. A managed care plan is required to develop comprehensive quality assurance standards to ensure their members are receiving and have access to quality health care services. Ky. Rev. Stat. § 304.17A-545.



meaningful insurer-provider relationship, there is no true benefit to the consumer.

Like the mandated benefit law in *Metropolitan Life* and the external review law in *Rush Prudential*, Kentucky's AWP statutes specifically regulate the terms of the insurance contract by allowing greater access to care and, thus, providing a richer benefit for the insured.

### B. Kentucky's AWP statutes meet the McCarran-Ferguson factors.

The Sixth Circuit ruled that Kentucky's AWP statutes meet all three McCarran-Ferguson factors. Pet. App. 30a-38a. This conclusion is correct. The McCarran-Ferguson factors confirm that Kentucky's AWP statutes are laws that regulate the business of insurance as a matter of common sense.

"[I]nsurance [is] a mechanism for shifting risk from one party to another in return for a premium payment, [and] every policy of insurance specifies which risk or risks that the insurer agrees to assume in return for the premiums called for by the insurance contract." 7 *Couch on Insurance*, § 101:1 (3d ed. 1997). Relying on the reasoning in *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500, 503 (4th Cir. 1993), *cert. denied*, 510 U.S. 1003 (1993), the Sixth Circuit concluded that Kentucky's AWP statutes satisfy the first McCarran-Ferguson factor because it has the effect of "transferring or spreading the policyholder's risk."[13] Pet. App. 30a. An insurer

[13] In *Stuart Circle*, the 4th Circuit concluded that Virginia's AWP statute related to ERISA plans but was saved from preemption because

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issuing an HMO, PPO, or POS health benefit plan must specify the in-network and out-of-network benefit for the insured. Thus, the insurer specifies which risk or risks the insurer is going to assume with regard to the insured's access to providers.

It is without a doubt that a patient's relationship with his or her health care provider is unique. It is a relationship based solely on trust. If an insurer arbitrarily prohibits a provider from participating in its network, many insureds, based on the relationship of trust and to ensure continuity of care, will choose to see the excluded provider.[14] In that situation, an insured enrolled in an HMO health benefit plan (no out-of-network benefit) will have to pay out-of-pocket to access that out-of-network provider – transferring the risk to the insured. If the insured is enrolled in a PPO or POS health benefit plan (with out-of-network benefits), the insured will take on additional liability to access the excluded provider of his or her choice.

Unlike the pharmacy agreements in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 214

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it regulated the business of insurance by spreading the cost component of policyholder's risk among all insureds because it "affects the type and cost of treatment available to an insured." *Stuart Circle*, 995 F.2d at 503. Additionally, the statute was an integral part of the policy relationship between insurer and insured, and the statute was expressly limited to entities within the insurance industry.

[14] In rural Kentucky, providers are scarce. Many areas of Kentucky are not close to an urban center. Additionally, many consumers only have one choice of insurer. Without Kentucky's AWP statutes, insurers would be allowed to further limit the choice of providers for Kentucky insureds.



(1979), Kentucky's AWP statutes are much more than "merely arrangements for the purchase of goods and services." To argue that an insured's preference for a particular health care provider, who has unique skill, experience, education, and personality, is similar to the pharmacy agreements in *Royal Drug* misses the point of AWP. Unlike Kentucky's AWP statutes, the pharmacy agreements in *Royal Drug* were created by the insurer to "minimize the cost[] Blue Shield incur[red] in fulfilling its underwriting obligations." *Id.* at 213. Instead, Kentucky's AWP statutes were the result of patient protection legislation to increase access to health care for insureds. An insured has an interest in and will have a preference for the health care provider who delivers the health care benefit under the policy. Petitioners would have this Court believe that insureds are no more concerned with whom their insurer contracts with to provide their health care services than they are with whom their insurer contracts with for janitorial services. This simply is not true.

Because insureds have a personal interest in their health care provider and will choose a provider to ensure the continuity of their care, Kentucky's AWP statutes transfer risk to insurers by reducing the possibility that insureds will have to pay out-of-pocket to see an out-of-network provider.

The second McCarran-Ferguson factor is also met. Kentucky's AWP statutes are "an integral part of the policy relationship between the insurer and the insured." *Rush Prudential*, 122 S.Ct. at 2163, quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982). The Sixth Circuit found this to be "unquestionably" true. Pet. App. 35a.

Kentucky's AWP statutes clearly affect the relationship between the insurer and the insured.[15] As stated previously, the certificate of coverage contains the "how, when, where, and why" of accessing a provider – the person who confers the benefit. As a matter of both law and function, the certificate of coverage cannot exist independently from the list of providers with whom the insurer has contracted.[16] This is especially true in Kentucky where most insurers, including Petitioners, issue managed care insurance policies (HMO, PPO, and POS). The certificate of coverage, along with the provider directory, "translate[] the relationship under the . . . agreement into concrete terms of specific obligation or freedom from duty." *Rush Prudential*, 122 S.Ct. at 2163.

Unlike the pharmacy agreements, in *Royal Drug*, Kentucky's AWP statutes are not simply a business decision made by insurers to reduce cost. Instead, Kentucky's AWP statutes function as a regulated mandate on insurers

[15] A hypothetical example of how AWP statutes work is as follows: A woman, in her second trimester of pregnancy, changes jobs either out of choice or necessity. She enrolls with her new employer's fully insured health benefit plan. She receives her certificate of coverage and provider directory. Upon reading the insurance materials, she notices that her obstetrician is not a listed provider. Understandably, she becomes concerned. When she contacts her insurer, her insurer is required to disclose that they will contract with any willing provider. Ky. Rev. Stat. § 304.17A-505(1)(k). She discusses this option with her obstetrician in order to have him contract with her insurer so that he can continue providing her with prenatal care. Kentucky's AWP statutes increase continuity of care, portability, and confer a benefit on the insured.

[16] Again, see Ky. Rev. Stat. § 304.17A-510 and Ky. Rev. Stat. § 304.17A-590 requiring an insurer to deliver the provider directory to the insured upon enrollment.



to offer a greater choice of providers to insureds and, thus, these statutes "change[] the bargain between insurer and insured." See *UNUM*, 526 U.S. at 374 (holding that California's notice-prejudice rule, which required the insurer to show actual prejudice from the insured's failure to give timely notice of claim, was an integral part of the policy relationship between insurer and insured). For these reasons, the second McCarran-Ferguson factor is met.

As the Sixth Circuit concluded, and for the same reasons that Kentucky's AWP statutes meet the common sense test, the third McCarran-Ferguson factor is met. Kentucky's AWP statutes are limited to entities within the insurance industry. Petitioners are insurers under Kentucky law. They hold certificates of authority issued by the Department of Insurance and, thus, fall under the regulatory authority of the Commissioner of Insurance. Unlike what Petitioners argue, Kentucky's AWP statutes do not apply to "entities acting solely as plan administrators"[17] Pet. App. 36a. Kentucky's AWP statutes, as written and as enforced, are laws regulating the business of insurance.

Although Kentucky's AWP statutes meet all three McCarran-Ferguson factors, "[i]t must be reiterated and emphasized that the three McCarran-Ferguson factors are not required to be satisfied before a state law can be found to be a law regulating insurance." Pet. App. 38a; see also *Rush Prudential*.

[17] Under Kentucky law, administrators do not and cannot issue "health benefit plans" as they are not insurers.

## III. PETITIONERS' RELIANCE ON *ROYAL DRUG* IS MISPLACED.

By relying on the 1979 antitrust case of *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), Petitioners have demonstrated their lack of understanding of the focus and need for Kentucky's AWP statutes. These statutes do not attempt to regulate the contract between the insurer and provider. Instead, they are intended to regulate the benefit of greater access to health care for insureds covered under Kentucky health benefit plans.

*Royal Drug* held that agreements between insurers and pharmacists were not exempt from the federal antitrust laws under Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b) because the agreements did not satisfy any of the McCarran-Ferguson factors. The insurer, in *Royal Drug*, attempted to enter into agreements with all pharmacies. The agreements allowed the insured to purchase drugs from a participating pharmacy for two dollars and, in return, the insurer would reimburse the pharmacy for the actual cost of the drugs. The non-participating pharmacies filed an antitrust action alleging that the insurer "had violated § 1 of the Sherman Act, 15 U.S.C. § 1, by entering agreements to fix the retail prices of drugs and pharmaceutical." *Id.* at 207. The insurer responded that its pharmacy agreements are the "business of insurance" and, therefore, are regulated by the state.[18]

[18] § 2(b) of the McCarran-Ferguson Act states "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance."



The majority in *Royal Drug* concluded that the insureds were "basically unconcerned with arrangements made between [the insurer] and participating pharmacies" and, therefore, the agreements did not fall under the business of insurance. *Id.* at 214. In *Royal Drug*, the insurer entered into the agreements with the participating pharmacy solely to set the reimbursement rate for the pharmacy. The decision to enter into these pharmacy agreements was a business decision made by the insurer.[19] Unlike the pharmacy agreements in *Royal Drug*, Kentucky's AWP statutes confer a benefit of choice and greater access on Kentucky's insureds.[20] Kentucky's AWP statutes determine who can be included in the insurer's network and, therefore, are of direct concern and benefit to the insured.[21] Unlike the private agreements in *Royal Drug*, the focus of Kentucky's AWP statutes is state regulation prohibiting the insurance practice of arbitrarily limiting provider panels.

It must be "presum[ed] that Congress did not intend to preempt areas of traditional state regulation." *Metropolitan Life*, 471 U.S. at 741, citing *Jones v. Rath Packing*

[19] The exemption in the McCarran-Ferguson Act is "for the 'business of insurance,' not the 'business of insurers.'" *Royal Drug*, 440 U.S. at 211.

[20] The concept of choice refers to the choice of provider to deliver a particular medical service. While one pharmacy may provide better customer service, there is no difference in the medical service. The prescription drug from the participating pharmacy is the same prescription drug available to the non-participating pharmacy.

[21] Kentucky's AWP statutes only confer the benefit of those providers listed in Ky. Rev. Stat. § 304.17A-005(19) on insureds. The Department has not promulgated any regulations to expand the list of providers in Ky. Rev. Stat. § 304.17A-005(19).

*Co.*, 430 U.S. 519, 525 (1977). Kentucky's AWP statutes are the types of state regulation of insurance contemplated by and allowed for under ERISA's saving clause. Unlike in the context of an exemption from the federal antitrust laws, which must be construed narrowly, *Department of Treasury v. Fabe*, 508 U.S. 491, 505 (1993), "[t]he presumption is against preemption" under the ERISA's saving clause. *Metropolitan Life*, 471 U.S. at 741.

For these reasons, the pharmacy agreements in *Royal Drug* are wholly distinguishable from the state regulatory scheme of Kentucky's AWP statutes.

## CONCLUSION

For the foregoing reasons, the judgment of the Sixth Circuit Court of Appeals should be affirmed.

Respectfully submitted,

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